

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for the investigation of complaint #IN00117084.</p> <p>COMPLAINT #IN00117084:</p> <p>SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W111, W148, W149, W153, W154 and W331.</p> <p>Dates of Survey: October 1, 2, 3, 4 and 5, 2012</p> <p>Facility number: 000736 Provider number: 15G209 AIM number: 100234620</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 10/17/12 by Tim Shebel, Medical Surveyor III.</p>			W0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (client A), the facility failed to ensure all pertinent information in regard to the client's health was part of the client's chart/records.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 10/1/12 from 5:30 P.M. until 6:30 P.M.. Upon entering the group home, client A's eye was observed to be dark black and blue from the inner corner to the outer corner of his left eye. Direct Support Professional (DSP) #1 indicated client A's eye has been like that for about a week.</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 10/2/12 at 1:55 P.M.. Review of the facility's BDDS reports indicated:</p>		W0111	<p>A procedure is in place but was not followed in this instance. The Community Services Nurse will be trained on the procedure to document injury and assessments. (10/29/12)</p> <p>To ensure future compliance the Community Services Nurse will document all treatments and assessments of any reported injury in the client medical chart.</p>		10/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>Incident dated 9/24/12: "[Client A] stated to the Health and Safety Tech, that over the weekend at his family (sic) house, he had a fight with an unnamed male, who hit him in his face. [Client A] did not report incident to staff over the weekend. Stated he (client A) forgot."</p> <p>A review of client A's record was conducted at the facility's administrative office on 10/2/12 at 3:30 P.M.. A review of client A's record failed to indicate nursing assessments to address client A's black eye or to indicate the client was sent to a physician for an assessment of his black eye. The last entry in client A's record was on 9/19/12 in regard to an unrelated audiogram follow-up.</p> <p>An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/3/12 at 2:49 P.M.. When asked if she assessed client A's injury of unknown injury, LPN #1 stated "I am not the nurse assigned to that group home, but I did go and look at [client A] on Wednesday, 9/26/12. Both of his eyes looked red and raw, not a black eye, but like he had allergies." The LPN indicated she did not document the injury in client A's record. The LPN further indicated all documentation should be documented in clients records.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	9-3-1(a)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 1 investigation records reviewed, involving 1 of 2 sampled clients (client A), the facility failed to immediately notify client A's advocate/health care representative/family member of an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 10/2/12 at 1:30 P.M.. A review of the investigation record indicated a Bureau of Developmental Disabilities Services (BDDS) report which indicated the following incident:</p> <p>Incident dated 9/24/12: "[Client A] stated to the Health and Safety Tech, that over the weekend at his family (sic) house, he had a fight with an unnamed male who hit him in his face. [Client A] did not report incident to staff over the weekend. Stated</p>		W0148	<p>A procedure for contacting family and/or guardians is in place. However the Service Coordinator was unable to reach the family at this time. The Behavioral Health Director will review the procedure with the Service Coordinator for proper reporting procedure. (10/29/12) To ensure future compliance the Service Coordinator will promptly notify parents or guardian/advocate of any significant incident or changes in the client's condition including but not limited to serious illness, accident, death, abuse, or unauthorized absence. W148-A procedure for contacting family and/or guardians is in place. However the Service Coordinator was unable to reach the family at this time. The Behavioral Health Director will review the procedure with the Service Coordinator for proper reporting procedure. (10/29/12) To ensure future compliance the Service Coordinator will promptly notify parents or guardian/advocate of any significant incident or changes in the client's condition including but not limited to serious illness,</p>		10/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>he (client A) forgot."</p> <p>Further review of the BDDS report dated 9/24/12 indicated: "Indicate which of the following agencies and individuals have been informed: Legal Guardian? N/A."</p> <p>An interview with the investigator was conducted at the facility's administrative office on 10/4/12 at 11:00 A.M.. The investigator indicated advocates/health care representatives/family members should be notified immediately when an incident occurs involving a client. When asked if client A's advocate/health care representative/family member was immediately notified, the investigator indicated he did not notify client A's advocate/health care representative/family member of the injury. No further documentation was available for review to indicate client A's advocate/health care representative/family member had been informed of the incident.</p> <p>An interview with the day program Health and Safety Tech (HST) was conducted on 10/4/12 at 1:00 P.M.. The HST indicated she was the person who documented client A's injury. The HST indicated she reported the injury immediately to her supervisor. The HST further indicated she did not contact client A's advocate/health care representative/family</p>				<p>accident, death, abuse, or unauthorized absence. Service Coordinator will document attempts and contacts made in case note form.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	member to make them aware of his injury. 9-3-2(a)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review and interview, for 1 of 1 investigation records of an injury of unknown origin reviewed involving 1 of 2 sampled clients (client A), the facility neglected to implement its "Policy for Handling Cases of Neglect and Abuse."</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 10/1/12 from 5:30 P.M. until 6:30 P.M.. Upon entering the group home, [client A] was observed to have dark black and blue coloring from his inner to outer left eye. When [client A] was asked what happened to his eye, he stated "A big white boy hit me in my eye." When asked where he was when the person hit him, he stated "At home."</p> <p>An interview with Direct Support Professional #1 (DSP) was conducted at the group home on 10/1/12 at 5:10 P.M.. DSP #1 stated "We don't know where [client A] got the black eye. At first he said he got it at home, then he said at the</p>			W0149	<p>Service Coordinator will review reporting requirements of abuse, neglect and exploitation of clients with the DSPs and document this review. Staff will monitor clients at all times for safety. (10/27/12) To ensure future compliance, an Area Manager, Service Coordinator and/or Community Services Nurse will monitor all incident reports regarding abuse, neglect, or exploitation as soon as they are submitted. An investigation will be conducted immediately if determined necessary for all injuries of unknown origin and/or reports of abuse, neglect, or exploitation.</p>		10/27/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>picnic and now they said it's from him rubbing his eyes because he has allergies."</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 10/2/12 at 1:55 P.M.. Review of the facility's BDDS reports indicated:</p> <p>Incident dated 9/24/12: "[Client A] stated to the Health and Safety Tech, that over the weekend at his family (sic) house, he had a fight with an unnamed male, who hit him in his face. [Client A] did not report incident to staff over the weekend. Stated he (client A) forgot."</p> <p>A review of investigation record #18085 dated 10/26/12 was conducted on 10/2/12 at 2:10 P.M.. Review of the record indicated the following:</p> <p>"Facts not supporting this allegation: Client keeps changing his story, now says nothing happened...At one point client said he got in fight at family home but client did not go to family home the weekend in question...Client has seasonal allergies and history of rubbing eyes and causing 'Black eye' to appear...Nurse looked at eye and did not see anything she would consider a black eye from being</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>hit...Based on the nursing evaluation and the changing (sometimes fictitious) stories my conclusion is that the client was not hit and caused the 'Black eye' inadvertently himself."</p> <p>"Date 9/26/12...Phone Interview: [Group home staff #3]: [Group home staff #3] saw a black eye Monday morning asked [client A] about it was told it happened at home, asked [client A] he said he went home over weekend [Group home staff #3] assumed it must have happened then...[Group home staff #3] says he recorded it in the log but did not do an incident report...[Group home staff #3] was on duty Monday morning."</p> <p>"Date 9/23/12...Phone Interview: [Group home staff #4]: [Group home staff #4] stated she worked Saturday and Sunday at Nebraska Group Home. She worked an 8:00 A.M. to 10:00 P.M. shift. She stated there was not any conflict with the other clients and [client A]. They did go to the agency picnic, but he did not go home with his family (he did the previous weekend). She did not notice anything wrong with his eye during her shift."</p> <p>"Date 9/26/12...Main Center: [Service Coordinator #1]: At approximately 10 A.M. on 9/24/12 I received a call from [Day program Health Safety Tech name]</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>who told me that [client A] came into the center with a black eye. [Client A] told staff that he was at his family's house and he was outside and a big white man hit him in the eye. Through further questions when I went to the group home to talk to [client A], he then told me that he was at the picnic in the bathroom and the white guy punched him in the eye. He also stated he hit the guy back. I asked if he knew the guy and he said 'No but he was nice.' I asked if the guy was a family person and he interrupted and said 'No he's like me. He talks like me.' Later questions on 9/25 did not determine who the second person was. [Client A] also has a history of seizures and severe seasonal allergies. [Client A] also has a BSP (Behavior Support Plan) with a targeted behavior of false reporting."</p> <p>"Date 9/26/12...Main: [Behavioral Health Director]: [Service Coordinator #1] informed me that [client A] had a black eye and that she had talked to him about it. He said that he was at the Fair Grounds talking to a male client in the bathroom and that that client hit him. When asked what he did about it [client A] stated he hit him back. [Service Coordinator #1]'s conversation with [client A] indicated that this was a big white guy that he was having a conversation with while in the bathroom.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>[Service Coordinator #1] and I developed a list of other residential male consumers that could have had a conversation with him and were looking to have him look at the pictures to figure out which client he had this altercation with. [Quality Assurance Director #1] came to my office while [Service Coordinator #1] and I were working on the list. I forwarded the list to [Service Coordinator #1] and then went to a meeting."</p> <p>"Date 9/26/12...[Day Program Supervisor #1]: The morning of September 24, 2012, [Health and Safety Tech #1] reported to me that [client A], got into a fight when he went home. I stated that he was at the picnic on Saturday, so [Health and Safety Tech #1] called [Service Coordinator #1] to find out if he was there and [Service Coordinator #1] told [Health and Safety Tech #1] that he went home after the picnic. [Health and Safety Tech#1] filled out an Incident/Accident report and did a BDDS (report)."</p> <p>"Date 9/26/12...West...[Health and Safety Tech #1]: Upon arriving at the center I was met by [client A] who stated to me look at my eye I had a fight. (sic) I asked what happen (sic), he said a boy hit him and they had a fight. I asked where and he stated I don't know (sic). I asked do you know anything about the boy, was he</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	a friend, he said no. I told him to have a seat. I went and informed [Day Program Supervisor #1], that [client A] was in my office, he stated he had been in a fight. I reported he had a black mark underneath his right eye and redness and scratches on the right side of his eye socket. She stated it didn't it didn't happen here. I told her I was going to contact [Service Coordinator #1], to see if she knew and had the staff made an incident report and a BDDS (report). I called [Service Coordinator #1], and informed her of [client A]'s injuries. She stated she had not been informed. I told her I would be doing an incident report and [client A] stated he was at home when incident happen (sic). After further questioning, she informed me that [client A] went home after the picnic, to question him which home, the group home or his family home. [Client A] would know the difference. I asked [client A] which home his group home with the other consumers or his family home with sister and brothers. He stated his family home. I called [Service Coordinator #1] and informed her that [client A] said it was his family home. She told me to make sure when I make the incident report and the BDDS (report) to make sure I put that the altercation did not happen at the group home, but at the family home. I informed [Day Program Supervisor #1] of my conversation with						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>[Service Coordinator #1], and I would be doing a BDDS and incident report. Upon further questioning, he informed me it happen at home. When he said home I informed [Day Program Supervisor #1] and she said [client A] was at picnic, that's when [Service Coordinator #1] asked me to ask [client A] which home, because he went to his family house after the picnic."</p> <p>"Date 9/26/12: West Center...[Client A]: Open ended questions...Do you live in Nebraska Group Home?... 'Yes.'...Did you do anything this last weekend...No answer...Did you go to the picnic?... 'Yes.'...Did you have fun?... 'Yes, I rode the swing.'...What happened to your eye?... 'Woke up and it was like that.'...Anybody hit you?... 'No.'...Are the group home staff mean to you?... 'No.'...Do you like the group home staff?... 'Yes.'...Are the center staff mean to you?... 'No.'...So you just woke up and your eye was like that?... 'Yes.'</p> <p>An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/3/12 at 2:49 P.M.. When asked if she assessed client A's injury of unknown injury, LPN #1 stated "I am not the nurse assigned to that group home, but I did go and look at [client A] on Wednesday, 9/26/12. Both of his eyes looked red and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>raw, not a black eye, but like he had allergies."</p> <p>A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/06 was conducted at the facility's administrative office on 10/3/12 at 3:14 P.M.. Review of the facility's policy indicated: "In order to protect the general welfare of the clients, [Facility Name], Inc. has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff. II. All allegations of abuse, neglect, humiliation or exploitation will be investigated per agency policy...Neglect- is defined as knowingly placing a client in a situation that poses a threat to his/her health and well-being. Examples include but are not limited to depriving a client of food, clothing, shelter or medical care; not providing adequate personal care, leaving clients unsupervised, etc...Internal investigation refers to a situation that can be successfully addressed within the department (possible examples include...an injury of unknown origin.)...When a staff person is involved, hears about, or witnesses an incident of suspected abuse/neglect or injury to a client...The staff person(s) observing or who has become aware of the incident must immediately: a. secure the safety of the individual(s) involved as</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>appropriate...b. begin the investigation procedure checklist...c. verbally inform his/her immediate supervisor of the suspected incident and/or individual responsible for that individuals program...d. submit an incident report recording all needed and necessary information to his/her supervisor...e. secure a first aid assessment if there is injury noted or suspected."</p> <p>An interview was conducted with the Quality Assurance Director (QAD) and Investigator of this investigation on 10/4/12 at 11:15 A.M.. When asked what date the injury of unknown origin was documented and reported, the QAD stated "Monday, 9/24/12, by the day program Health and Safety Tech." When asked what date the investigation into this injury of unknown origin involving client A begin, the investigator stated, "Wednesday, 9/26/12." When asked if the investigation was started the day the incident was reported, the investigator stated "No." When asked how [Group home staff #3] described [client A]'s injury, he stated "He said he had a black eye." When asked what day [Group home staff #3] said he saw [client A] had a "black eye", the investigator stated, "Monday morning, 9/24/12." When asked how did [Day Program Health and Safety Tech #1] describe [client A]'s</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>injury, the investigator stated "She stated he had a black eye on Monday morning, 9/24/12." When asked if he contacted client A's family members during the investigation, the investigator stated "No, I did not." When asked if he went in person to see client A's reported injury, the investigator stated, "Yes, on Wednesday, 9/26/12 with [LPN #1]." When asked if he could describe what he saw, the investigator stated "His eyes were red and puffy and there were some scratches as if he had been rubbing his eyes because of allergies." When asked if client A had a black eye when he saw him on 9/26/12, the investigator stated, "My interpretation of a black eye may be different from your interpretation." When asked to describe what he considered a black eye, the investigator stated, "Black and blue coloring around the eye area." When asked if client A's injury of unknown origin was immediately reported, the investigator stated "No." When asked how he came to the conclusion of the investigation, the investigator stated, "Based on the nursing assessment and [client A]'s history of rubbing his eyes due to allergies."</p> <p>A day program observation was conducted at the facility owned day program on 10/4/12 from 1:00 P.M. until 2:00 P.M.. Upon entering a conference</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>room to interview [Day Program Health and Safety Tech #1], [client A] was sitting at the conference table. Day Program Supervisor #2 and Health and Safety Tech #1 were asked if they could describe client A's eye. Both responded, "He has a black eye."</p> <p>An interview with Day Program Health and Safety Tech #1 was conducted on 10/4/12 at 1:10 P.M.. Day Program Health and Safety Tech #1 indicated, client A entered the day program on Monday morning, 9/24/12 with a black eye. When asked if she could describe client A's eye, she stated "It was dark black and blue from the inner to outer underneath eye. He had a dark red mark on the side by his temple and a few scratches, like someone had punched him. His eyes were not red, or swollen and his eye ball was not red in color, like when someone has allergies." When asked how client A explained how he got the injury, she stated, "He said someone beat him up when he was at home." When asked if group home staff informed her of the injury when transporting to the day program, she stated "No." When asked what is the facility's policy and procedure for reporting injuries of unknown origin, Day Program Health and Safety Tech #1 stated "We must immediately notify our supervisor and immediately document on</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	an internal incident/accident report and immediately report it to BDDS." 9-3-2(a)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident of injury of unknown origin involving 1 of 2 sampled clients (client A), to report immediately to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 10/2/12 at 1:55 P.M.. Review of the facility's BDDS reports indicated:</p> <p>Incident dated 9/24/12: "[Client A] stated to the Health and Safety Tech, that over the weekend at his family (sic) house, he had a fight with an unnamed male, who hit him in his face. [Client A] did not report incident to staff over the weekend. Stated he forgot."</p> <p>A review of investigation record #18085 dated 10/26/12 was conducted on 10/2/12</p>		W0153	<p>A procedure is in place but was not followed in this instance. The Health and Safety Tech and the DSPs will be retrained on reporting procedures and training will be documented. (10/29/12) To ensure future compliance any person informed of incident of abuse, neglect, exploitation or injury of unknown origin will inform the administrator promptly after being made aware of incident.</p>		10/29/2012	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>at 2:10 P.M.. Review of the record indicated the following:</p> <p>"Date 9/26/12...Phone Interview: [Group home staff #3]: [Group home staff #3] saw a black eye Monday morning asked [client A] about it was told it happened at home, asked [client A] he said he went home over weekend [Group home staff #3] assumed it must have happened then...[Group home staff #3] says he recorded it in the log but did not do an incident report...[Group home staff #3] was on duty Monday morning."</p> <p>An interview was conducted with the Service Coordinator (SC) at the facility's administrative office on 10/4/12 at 11:55 A.M.. The SC indicated the incident was not immediately reported by the group home staff to the administrator. The SC stated "Incidents are to be reported immediately to the administrator."</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review and interview for 1 of 1 investigation record of injury of unknown origin, involving 1 of 2 sampled clients (client A) the facility failed to conduct a thorough investigation.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 10/1/12 from 5:30 P.M. until 6:30 P.M.. Upon entering the group home, [client A] was observed to have dark black and blue coloring from his inner to outer left eye. When [client A] was asked what happened to his eye, he stated "A big white boy hit me in my eye." When asked where he was when the person hit him, he stated "At home."</p> <p>An interview with Direct Support Professional #1 (DSP) was conducted at the group home on 10/1/12 at 5:10 P.M.. DSP #1 stated "We don't know where [client A] got the black eye. At first he said he got it at home, then he said at the picnic and now they said it's from him rubbing his eyes because he has allergies."</p>			W0154	<p>The Quality Assurance Director shall review notification dates and responsibilities with investigators when the investigation is assigned. Upon completion, the investigation shall be provided to the responsible administrator. To monitor completion and compliance the Quality Assurance Director shall develop a database for tracking investigations.</p>		10/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 10/2/12 at 1:55 P.M.. Review of the facility's BDDS reports indicated:</p> <p>Incident dated 9/24/12: "[Client A] stated to the Health and Safety Tech, that over the weekend at his family (sic) house, he had a fight with an unnamed male, who hit him in his face. [Client A] did not report incident to staff over the weekend. Stated he forgot."</p> <p>A review of investigation record #18085 dated 10/26/12 was conducted on 10/2/12 at 2:10 P.M.. Review of the record indicated the following:</p> <p>"Facts not supporting this allegation: Client keeps changing his story, now says nothing happened...At one point client said he got in fight at family home but client did not go to family home the weekend in question...Client has seasonal allergies and history of rubbing eyes and causing 'Black eye' to appear...Nurse looked at eye and did not see anything she would consider a black eye from being hit...Based on the nursing evaluation and the changing (sometimes fictitious) stories my conclusion is that the client was not</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>hit and caused the 'Black eye' inadvertently himself."</p> <p>"Date 9/26/12...Phone Interview: [Group home staff #3]: [Group home staff #3] saw a black eye Monday morning asked [client A] about it was told it happened at home, asked [client A] he said he went home over weekend [Group home staff #3] assumed it must have happened then...[Group home staff #3] says he recorded it in the log but did not do an incident report...[Group home staff #3] was on duty Monday morning."</p> <p>"Date 9/23/12...Phone Interview: [Group home staff #4]: [Group home staff #4] stated she worked Saturday and Sunday at Nebraska Group Home. She worked an 8:00 A.M. to 10:00 P.M. shift. She stated there was not any conflict with the other clients and [client A]. They did go to the agency picnic, but he did not go home with his family (he did the previous weekend). She did not notice anything wrong with his eye during her shift."</p> <p>"Date 9/26/12...Main Center: [Service Coordinator #1]: At approximately 10 A.M. on 9/24/12 I received a call from [Day program Health Safety Tech name] who told me that [client A] came into the center with a black eye. [Client A] told staff that he was at his family's house and</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>he was outside and a big white man hit him in the eye. Through further questions when I went to the group home to talk to [client A], he then told me that he was at the picnic in the bathroom and the white guy punched him in the eye. He also stated he hit the guy back. I asked if he knew the guy and he said 'No but he was nice.' I asked if the guy was a family person and he interrupted and said 'No he's like me. He talks like me.' Later questions on 9/25 did not determine who the second person was. [Client A] also has a history of seizures and severe seasonal allergies. [Client A] also has a BSP (Behavior Support Plan) with a targeted behavior of false reporting."</p> <p>"Date 9/26/12...Main: [Behavioral Health Director]: [Service Coordinator #1] informed me that [client A] had a black eye and that she had talked to him about it. He said that he was at the Fair Grounds talking to a male client in the bathroom and that that client hit him. When asked what he did about it [client A] stated he hit him back. [Service Coordinator #1]'s conversation with [client A] indicated that this was a big white guy that he was having a conversation with while in the bathroom. [Service Coordinator #1] and I developed a list of other residential male consumers that could have had a conversation with</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>him and were looking to have him look at the pictures to figure out which client he had this altercation with. [Quality Assurance Director #1] came to my office while [Service Coordinator #1] and I were working on the list. I forwarded the list to [Service Coordinator #1] and then went to a meeting."</p> <p>"Date 9/26/12...[Day Program Supervisor #1]: The morning of September 24, 2012, [Health and Safety Tech #1] reported to me that [client A], got into a fight when he went home. I stated that he was at the picnic on Saturday, so [Health and Safety Tech #1] called [Service Coordinator #1] to find out if he was there and [Service Coordinator #1] told [Health and Safety Tech #1] that he went home after the picnic. [Health and Safety Tech#1] filled out an Incident/Accident report and did a BDDS (report)."</p> <p>"Date 9/26/12...West...[Health and Safety Tech #1]: Upon arriving at the center I was met by [client A] who stated to me look at my eye I had a fight. (sic) I asked what happen (sic), he said a boy hit him and they had a fight. I asked where and he stated I don't know (sic). I asked do you know anything about the boy, was he a friend, he said no. I told him to have a seat. I went and informed [Day Program Supervisor #1], that [client A] was in my</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	office, he stated he had been in a fight. I reported he had a black mark underneath his right eye and redness and scratches on the right side of his eye socket. She stated it didn't it didn't happen here. I told her I was going to contact [Service Coordinator #1], to see if she knew and had the staff made an incident report and a BDDS. I called [Service Coordinator #1], and informed her of [client A]'s injuries. She stated she had not been informed. I told her I would be doing an incident report and [client A] stated he was at home when incident happen (sic). After further questioning, she informed me that [client A] went home after the picnic, to question him which home, the group home or his family home. [Client A] would know the difference. I asked [client A] which home his group home with the other consumers or his family home with sister and brothers. He stated his family home. I called [Service Coordinator #1] and informed her that [client A] said it was his family home. She told me to make sure when I make the incident report and the BDDS (report) to make sure I put that the altercation did not happen at the group home, but at the family home. I informed [Day Program Supervisor #1] of my conversation with [Service Coordinator #1], and I would be doing a BDDS and incident report. Upon further questioning, he informed me it happen at home. When						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>he said home I informed [Day Program Supervisor #1] and she said [client A] was at picnic, that's when [Service Coordinator #1] asked me to ask [client A] which home, because he went to his family house after the picnic."</p> <p>"Date 9/26/12: West Center...[Client A]: Open ended questions...Do you live in Nebraska Group Home?... 'Yes.'...Did you do anything this last weekend...No answer...Did you go to the picnic?... 'Yes.'...Did you have fun?... 'Yes, I rode the swing.'...What happened to your eye?... 'Woke up and it was like that.'...Anybody hit you?... 'No.'...Are the group home staff mean to you?... 'No.'...Do you like the group home staff?... 'Yes.'...Are the center staff mean to you?... 'No.'...So you just woke up and your eye was like that?... 'Yes.'</p> <p>An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/3/12 at 2:49 P.M.. When asked if she assessed client A's injury of unknown injury, LPN #1 stated "I am not the nurse assigned to that group home, but I did go and look at [client A] on Wednesday, 9/26/12. Both of his eyes looked red and raw, not a black eye, but like he had allergies."</p> <p>An interview was conducted with the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>Quality Assurance Director (QAD) and Investigator of this investigation on 10/4/12 at 11:15 A.M.. When asked what date the injury of unknown origin was documented and reported, the QAD stated "Monday, 9/24/12, by the day program Health and Safety Tech." When asked what date the investigation into this injury of unknown origin involving client A begin, the investigator stated, "Wednesday, 9/26/12." When asked if the investigation was started the day the incident was reported, the investigator stated "No." When asked how [Group home staff #3] described [client A]'s injury, he stated "He said he had a black eye." When asked what day [Group home staff #3] said he saw [client A] had a "black eye", the investigator stated, "Monday morning, 9/24/12." When asked how did [Day Program Health and Safety Tech #1] describe [client A]'s injury, the investigator stated "She stated he had a black eye on Monday morning, 9/24/12." When asked if he contacted client A's family members during the investigation, the investigator stated "No, I did not." When asked if he went in person to see client A's reported injury, the investigator stated, "Yes, on Wednesday, 9/26/12 with [LPN #1]." When asked if he could describe what he saw, the investigator stated "His eyes were red and puffy and there were some</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>scratches as if he had been rubbing his eyes because of allergies." When asked if client A had a black eye when he saw him on 9/26/12, the investigator stated, "My interpretation of a black eye may be different from your interpretation." When asked to describe what he considered a black eye, the investigator stated, "Black and blue coloring around the eye area." When asked if client A's injury of unknown origin was immediately reported, the investigator stated "No." When asked how he came to the conclusion of the investigation, the investigator stated, "Based on the nursing assessment and [client A]'s history of rubbing his eyes due to allergies."</p> <p>A day program observation was conducted at the facility owned day program on 10/4/12 from 1:00 P.M. until 2:00 P.M.. Upon entering a conference room to interview [Day Program Health and Safety Tech #1], [client A] was sitting at the conference table. Day Program Supervisor #2 and Health and Safety Tech #1 were asked if they could describe client A's eye. Both responded, "He has a black eye."</p> <p>An interview with Day Program Health and Safety Tech #1 was conducted on 10/4/12 at 1:10 P.M.. Day Program Health and Safety Tech #1 indicated,</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>client A entered the day program on Monday morning, 9/24/12 with a black eye. When asked if she could describe client A's eye, she stated "It was dark black and blue from the inner to outer underneath eye. He had a dark red mark on the side by his temple and a few scratches, like someone had punched him. His eyes were not red, or swollen and his eye ball was not red in color, like when someone has allergies." When asked how client A explained how he got the injury, she stated, "He said someone beat him up when he was at home." When asked if group home staff informed her of the injury when transporting to the day program, she stated "No." When asked what is the facility's policy and procedure for reporting injuries of unknown origin, Day Program Health and Safety Tech #1 stated "We must immediately notify our supervisor and immediately document on an internal incident/accident report and immediately report it to BDDS."</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 2 sampled clients (client A), the facility failed to provide nursing services for the clients injury.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 10/1/12 from 5:30 P.M. until 6:30 P.M.. Upon entering the group home, [client A] was observed to have dark black and blue coloring from his inner to outer left eye. When [client A] was asked what happened to his eye, he stated "A big white boy hit me in my eye." When asked where he was when the person hit him, he stated "At home."</p> <p>An interview with Direct Support Professional #1 (DSP) was conducted at the group home on 10/1/12 at 5:10 P.M.. DSP #1 stated "We don't know where [client A] got the black eye. At first he said he got it at home, then he said at the picnic and now they said it's from him rubbing his eyes because he has allergies."</p>		W0331	<p>A procedure is in place but was not followed in this instance. The Community Services Nurse will be retrained in injury assessment procedures. (10/29/12) To ensure future compliance the Community Services Nurse will assess all clients within 24 hours of any reported injury. Nurse will determine if any further medical treatment is required and follow up on the recommendation where further treatment is warranted.</p>		10/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 10/2/12 at 1:55 P.M.. Review of the facility's BDDS reports indicated:</p> <p>Incident dated 9/24/12: "[Client A] stated to the Health and Safety Tech, that over the weekend at his family (sic) house, he had a fight with an unnamed male, who hit him in his face. [Client A] did not report incident to staff over the weekend. Stated he (client A) forgot."</p> <p>A review of investigation record #18085 dated 9/26/12 was conducted on 10/2/12 at 2:10 P.M.. Review of the record indicated the following:</p> <p>"Facts not supporting this allegation: Client keeps changing his story, now says nothing happened...At one point client said he got in fight at family home but client did not go to family home the weekend in question...Client has seasonal allergies and history of rubbing eyes and causing 'Black eye' to appear...Nurse looked at eye and did not see anything she would consider a black eye from being hit...Based on the nursing evaluation and the changing (sometimes fictitious) stories my conclusion is that the client was not hit and caused the 'Black eye'</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>inadvertently himself."</p> <p>"Date 9/26/12...Phone Interview: [Group home staff #3]: [Group home staff #3] saw a black eye Monday morning asked [client A] about it was told it happened at home, asked [client A] he said he went home over weekend [Group home staff #3] assumed it must have happened then...[Group home staff #3] says he recorded it in the log but did not do an incident report...[Group home staff #3] was on duty Monday morning."</p> <p>"Date 9/23/12...Phone Interview: [Group home staff #4]: [Group home staff #4] stated she worked Saturday and Sunday at Nebraska Group Home. She worked an 8:00 A.M. to 10:00 P.M. shift. She stated there was not any conflict with the other clients and [client A]. They did go to the agency picnic, but he did not go home with his family (he did the previous weekend). She did not notice anything wrong with his eye during her shift."</p> <p>"Date 9/26/12...Main Center: [Service Coordinator #1]: At approximately 10 A.M. on 9/24/12 I received a call from [Day program Health Safety Tech name] who told me that [client A] came into the center with a black eye. [Client A] told staff that he was at his family's house and he was outside and a big white man hit</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>him in the eye. Through further questions when I went to the group home to talk to [client A], he then told me that he was at the picnic in the bathroom and the white guy punched him in the eye. He also stated he hit the guy back. I asked if he knew the guy and he said 'No but he was nice.' I asked if the guy was a family person and he interrupted and said 'No he's like me. He talks like me.' Later questions on 9/25 did not determine who the second person was. [Client A] also has a history of seizures and severe seasonal allergies. [Client A] also has a BSP (Behavior Support Plan) with a targeted behavior of false reporting."</p> <p>"Date 9/26/12...Main: [Behavioral Health Director]: [Service Coordinator #1] informed me that [client A] had a black eye and that she had talked to him about it. He said that he was at the Fair Grounds talking to a male client in the bathroom and that that client hit him. When asked what he did about it [client A] stated he hit him back. [Service Coordinator #1]'s conversation with [client A] indicated that this was a big white guy that he was having a conversation with while in the bathroom. [Service Coordinator #1] and I developed a list of other residential male consumers that could have had a conversation with him and were looking to have him look at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>the pictures to figure out which client he had this altercation with. [Quality Assurance Director #1] came to my office while [Service Coordinator #1] and I were working on the list. I forwarded the list to [Service Coordinator #1] and then went to a meeting."</p> <p>"Date 9/26/12...[Day Program Supervisor #1]: The morning of September 24, 2012, [Health and Safety Tech #1] reported to me that [client A], got into a fight when he went home. I stated that he was at the picnic on Saturday, so [Health and Safety Tech #1] called [Service Coordinator #1] to find out if he was there and [Service Coordinator #1] told [Health and Safety Tech #1] that he went home after the picnic. [Health and Safety Tech#1] filled out an Incident/Accident report and did a BDDS (report)."</p> <p>"Date 9/26/12...West...[Health and Safety Tech #1]: Upon arriving at the center I was met by [client A] who stated to me look at my eye I had a fight. (sic) I asked what happen (sic), he said a boy hit him and they had a fight. I asked where and he stated I don't know (sic). I asked do you know anything about the boy, was he a friend, he said no. I told him to have a seat. I went and informed [Day Program Supervisor #1], that [client A] was in my office, he stated he had been in a fight. I</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	reported he had a black mark underneath his right eye and redness and scratches on the right side of his eye socket. She stated it didn't it didn't happen here. I told her I was going to contact [Service Coordinator #1], to see if she knew and had the staff made an incident report and a BDDS. I called [Service Coordinator #1], and informed her of [client A]'s injuries. She stated she had not been informed. I told her I would be doing an incident report and [client A] stated he was at home when incident happen (sic). After further questioning, she informed me that [client A] went home after the picnic, to question him which home, the group home or his family home. [Client A] would know the difference. I asked [client A] which home his group home with the other consumers or his family home with sister and brothers. He stated his family home. I called [Service Coordinator #1] and informed her that [client A] said it was his family home. She told me to make sure when I make the incident report and the BDDS to make sure I put that the altercation did not happen at the group home, but at the family home. I informed [Day Program Supervisor #1] of my conversation with [Service Coordinator #1], and I would be doing a BDDS and incident report. Upon further questioning, he informed me it happen at home. When he said home I informed [Day Program						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Supervisor #1] and she said [client A] was at picnic, that's when [Service Coordinator #1] asked me to ask [client A] which home, because he went to his family house after the picnic."</p> <p>"Date 9/26/12: West Center...[Client A]: Open ended questions...Do you live in Nebraska Group Home?... 'Yes.'...Did you do anything this last weekend...No answer...Did you go to the picnic?... 'Yes.'...Did you have fun?... 'Yes, I rode the swing.'...What happened to your eye?... 'Woke up and it was like that.'...Anybody hit you?... 'No.'...Are the group home staff mean to you?... 'No.'...Do you like the group home staff?... 'Yes.'...Are the center staff mean to you?... 'No.'...So you just woke up and your eye was like that?... 'Yes.'</p> <p>A review of client A's record was conducted at the facility's administrative office on 10/2/12 at 3:30 P.M.. A review of client A's record failed to indicate nursing assessments to address client A's black eye or to indicate the client was sent to a physician for an assessment of his black eye. The last entry in client A's record indicated: "9/19/12...Audiogram-normal hearing in each ear, recommend re-eval in 3 years...RTO (return) 3 yr (3 years).</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>An interview with Licensed Practical Nurse #1 (LPN) was conducted on 10/3/12 at 2:49 P.M.. When asked if she assessed client A's injury of unknown injury, LPN #1 stated "I am not the nurse assigned to that group home, but I did go and look at [client A] on Wednesday, 9/26/12. Both of his eyes looked red and raw, not a black eye, but like he had allergies."</p> <p>An interview was conducted with the Quality Assurance Director (QAD) and Investigator of this investigation on 10/4/12 at 11:15 A.M.. When asked what date the injury of unknown origin was documented and reported, the QAD stated "Monday, 9/24/12, by the day program Health and Safety Tech." When asked what date the investigation into this injury of unknown origin involving client A begin, the investigator stated, "Wednesday, 9/26/12." When asked if the investigation was started the day the incident was reported, the investigator stated "No." When asked how [Group home staff #3] described [client A]'s injury, he stated "He said he had a black eye." When asked what day [Group home staff #3] said he saw [client A] had a "black eye", the investigator stated, "Monday morning, 9/24/12." When asked how did [Day Program Health and Safety Tech #1] describe [client A]'s</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>injury, the investigator stated "She stated he had a black eye on Monday morning, 9/24/12." When asked if he contacted client A's family members during the investigation, the investigator stated "No, I did not." When asked if he went in person to see client A's reported injury, the investigator stated, "Yes, on Wednesday, 9/26/12 with [LPN #1]." When asked if he could describe what he saw, the investigator stated "His eyes were red and puffy and there were some scratches as if he had been rubbing his eyes because of allergies." When asked if client A had a black eye when he saw him on 9/26/12, the investigator stated, "My interpretation of a black eye may be different from your interpretation." When asked to describe what he considered a black eye, the investigator stated, "Black and blue coloring around the eye area." When asked if client A's injury of unknown origin was immediately reported, the investigator stated "No." When asked how he came to the conclusion of the investigation, the investigator stated, "Based on the nursing assessment and [client A]'s history of rubbing his eyes due to allergies."</p> <p>A day program observation was conducted at the facility owned day program on 10/4/12 from 1:00 P.M. until 2:00 P.M.. Upon entering a conference</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>room to interview [Day Program Health and Safety Tech #1], [client A] was sitting at the conference table. Day Program Supervisor #2 and Health and Safety Tech #1 were asked if they could describe client A's eye. Both responded, "He has a black eye."</p> <p>An interview with Day Program Health and Safety Tech #1 was conducted on 10/4/12 at 1:10 P.M.. Day Program Health and Safety Tech #1 indicated, client A entered the day program on Monday morning, 9/24/12 with a black eye. When asked if she could describe client A's eye, she stated "It was dark black and blue from the inner to outer underneath eye. He had a dark red mark on the side by his temple and a few scratches, like someone had punched him. His eyes were not red, or swollen and his eye ball was not red in color, like when someone has allergies." When asked how client A explained how he got the injury, she stated, "He said someone beat him up when he was at home." When asked if group home staff informed her of the injury when transporting to the day program, she stated "No." When asked what is the facility's policy and procedure for reporting injuries of unknown origin, Day Program Health and Safety Tech #1 stated "We must immediately notify our supervisor and immediately document on</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/05/2012	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>an internal incident/accident report and immediately report it to BDDS."</p> <p>No documentation was available for review to indicate nursing staff assessed/treated client A's injury of unknown injury.</p> <p>9-3-6(a)</p>						